

NOTICE OF INDEPENDENT REVIEW DECISION

October 02, 2002

RE: MDR Tracking #: M2-02-1091-01
IRO Certificate #: 4326

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to ___ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in chiropractic care. ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This 19 year old male sustained a work-related injury on ___ when he slipped and fell into a ditch while doing construction work. The patient reported immediately experiencing pain in his back with radiation down the right leg. The primary diagnoses were facet syndrome and lumbar intervertebral disc (IVD) syndrome. Secondary diagnoses were myalgia/myositis and radiculitis. He has received medications for pain and inflammation as well as active and passive modalities. The treating chiropractor has recommended work hardening.

Requested Service(s)

Work hardening

Decision

It has been determined that work hardening is not medically necessary.

Rationale/Basis for Decision

The medical record revealed that the patient was injured on ____ when he slipped in a ditch while doing construction work. The patient was diagnosed with lumbar IVD syndrome and facet syndrome. A subsequent lumbar MRI ruled out disc herniation. The patient was initially treated with passive and active care and was performing 60 minutes of therapeutic exercises and 30 minutes of gym ball exercises on the following dates in May of 2002: 8, 9, 10, 13, 15, 17, 22, and 24. The patient's initial lumbar ranges of motion were as follows: flexion= 30 degrees, extension= 10 degrees, left lateral flexion= 12 degrees and right lateral flexion= 10 degrees. The re-evaluation on 06/18/02 revealed that the patient's lumbar ranges of motion were as follows: flexion= 44 degrees, extension= 12 degrees, left lateral flexion= 13 degrees and right lateral flexion= 12 degrees. Thus, in spite of the extensive course of passive and active care, the patient's lumbar ranges of motion were still inadequate. The initial functional capacity evaluation (FCE), done on 06/20/02, revealed that the patient could only lift 13 lbs from the floor to knuckle height, 8 lbs from the knuckle height to the shoulders, 3 lbs from the shoulders to overhead, and he could only carry 15 lbs for 20 feet. The patient's physical performance was inadequate. A patient should only be admitted to a work hardening program if it is probable that the patient will successfully complete the program. In light of the examination findings and the inconsistencies noted between the previous month of exercises for 1.5 hours a day and the observed performance during the FCE, this patient is not an appropriate candidate for work hardening. Therefore, work hardening is not medically necessary.

This decision by the IRO is deemed to be a TWCC decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10** (10) days of your receipt of this decision (20 Tex. Admin. Code 142.5 (c)).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin Code 148.3).

This Decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin Code 102.4(h) or 102.5(d)). A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Workers' Compensation Commission, P.O. Box 40669, Austin, Texas, 78704-0012. **A copy of this decision should be attached to the request.**

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute (Commission Rule 133.308 (t)(2)).

Sincerely,